VIRGINIA UNIFORM ASSESSMENT INSTRUMENT
For Private Pay Residents of Assisted Living Facilities

Dates: Assessment: ____/____/____
Reassessment: ____/____/____

1. IDENTIFICATION

Name: _____ **Social Security Number**: _____
(Last) (First) (Middle Initial)

Current Address: _____
(Street) (City) (State) (Zip Code)

Phone: (_____)_____

Birth date: _____/_____/_____ **Sex:** ____Male 0 ____Female 1
(Month) (Day) (Year)

Marital Status: ____Married 0 ____Widowed 1 ____Separated 2 ____Divorced 3 ____Single 4 ____ Unknown 9

2. FUNCTIONAL STATUS (Check only one block for each level of functioning) D = Dependent or Totally Dependent (TD or DD)

	Needs Help?		d **Mechanical Help Only** 10	D **Human Help Only** 2		D **Mechanical & Human Help** 3		D/TD **Performed by Others** 40			D/TD **Is Not Performed** 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	**Needs Help?**		d **Incontinent** Less than weekly 1	d **Ext. Device/ Indwelling/ Ostomy** Self Care 2	D **Incontinent** Weekly or More 3	D/TD **External Device** Not Self Care 4	D/TD **Indwelling Catheter** Not Self Care 5	D/TD **Ostomy** Not Self Care 6
	No 0	If Yes Check Type of Help						
Bowel								
Bladder								

AMBULATION	**Needs Help?**		**Mechanical Help Only** 10	**Human Help Only** 2		**Mechanical & Human Help** 3		**Performed by Others** 40	**Is Not Performed** 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

2. FUNCTIONAL STATUS *(Continued)*

D = Dependent

IADLS	Needs Help?	
	No 0	Yes 1 D
Meal Prep		
Housekeeping		
Laundry		
Money Mgmt.		

Medication Administration
How can you take your medicine?
_____ Without assistance 0
_____ Administered/monitored by lay person 1 D
_____ Administered/monitored by professional nursing staff 2 D
Describe help/Name of helper:

3. PSYCHO-SOCIAL STATUS

Behavior Pattern	Orientation
_____ Appropriate 0 _____ Wandering/Passive - Less than weekly 1 _____ Wandering/Passive - Weekly or more 2 d _____ Abusive/Aggressive/Disruptive - Less than weekly 3 D _____ Abusive/Aggressive/Disruptive - Weekly or more 4 D _____ Comatose 5 D	_____ Oriented 0 _____ Disoriented - Some spheres, some of the time 1 d _____ Disoriented - Some spheres, all the time 2 d _____ Disoriented - All spheres, some of the time 3 D _____ Disoriented - All spheres, all of the time 4 D _____ Comatose 5 D
Type of inappropriate behavior:	Spheres affected:

Current psychiatric or psychological evaluation needed? _____ No 0 _____ Yes 1

4. ASSESSMENT SUMMARY

Prohibited Conditions

Does applicant/resident have a prohibited condition? _____ No 0 _____ Yes 1
Describe:

Level of Care Approved

1) Residential Living _____ 2) Assisted Living _____ 3) Intensive Assisted Living _____
(for private pay residents only; not for Auxiliary Grant recipients)

Assessment Completed by:

Assessor	Assessor's Signature	Agency/Assisted Living Facility Name	Date

If the assessor is an assisted living facility employee, the administrator or designee must signify approval by signing below:

_____ _____ _____
Administrator or Designee Signature Title Date

_____ _____ _____
Administrator or Designee Signature Title Date

Comments:

Note: Form must be filed in private pay resident's record upon completion.